3/1/2006 Peer Review Report Meeting – Led by Howard Hatayama
(Notes by Carol Ingram)

Ask: Are questions in Peer Review Report widespread and have they shown up in other reports over the past few years, dating back to 2003?

Attendees:
Eugene Lau, John Chernowski, Jack Bartley, Weyland Wong, Michelle Flynn, Pat Thomas, Rick Kelley, Richard DeBusk, Howard Hatayama, Peter Lichty, Don Lucas and Carol Ingram.

Difficult - Reports are differing in focus, breadth.

Peer Review Report binned by ISM guiding principles and taken suggestions in four areas in four areas: HR, Education and Training, Communication, Work and Operations using causal analysis tree from ORPS because used in many reports.

Schedule - to submit CAP by March 17, 2006 to DOE. After today, we'll know better how good the date is and can revise as necessary to develop quality product.
(I introduced myself as an observer on behalf of the validation team.)

Howard also mentioned the DNFSB recommended 2004-1, Commitments 23 & 25 wrote "include assessment of vulnerabilities in CAP."
Core Team tried to bin Peer Review findings into the root cause analysis tree, did crosswalk. Pattern noted on where root causes fell out.

Can we learn....
Jack: By rolling up, this is a great opportunity for improvements across the site, we could make this of great value across the site.

Richard asked if they did analysis of the program e.g. electrical program – Yes, getting full span.

Richard – we don't normally look across entire institution, Richard called for questioning attitude.

Howard wrote: Systematic review of effectiveness of EHS programs

Richard: There are only four reports. We ought to have 40, but they don't exist. Hopefully they will at some time.

John: Went down to only A & B levels on Root Cause Analysis tree.

Would like the teams to go to C categories – Distributed Casual Analysis Tree and Summary of Findings.

Richard noted that the Peer Review Report didn't identify **anything** under Human Performance, even though ALS, injuries and electrical did. **Jack** said the core team discussed that, and noted that since the Peer Review was hearing so much about fear of reporting and negative effects, they went out of their way to avoid saying anything about individual human performances being a cause.

Weyland pointing out that to look at ALS may not be reflective of site. They have procedures, follow them, update, unlike rest of the site. Yet they fell down – Pointed out that we could learn through individuals taking short cut.

Peter – need to look at culpability.

Jack – Pointed out Peer Review should have looked at resources.

Weyland – Roles and responsibility. Discussion about the culture at ALS, procedures are lengthy, people/users more likely to rely on others. Beamline coordinators have a lot of responsibilities, people don't look at PUB 3000, they ask their supervisor, who may teach them wrong.

Danger of placing everything on manager, lose accountability on individual if place on system. Flaw of finding only one root cause.

Break

IFA didn't check for interlocks in our lab
IFA process has deteriorated because EHS hasn't had staff, don't think comprehensive review
IFA – quick walkthrough, haven't always has any lab people there

Weyland – "What is purpose of what we do?" "What are you looking for?" aren't always asked. Question whether what we're doing with IFAs, etc., is going to be sufficient. Changes are being made, but more may come of this.

Need for clear limits defined for work authorization (not just paper), even when you send someone out to do work, maintenance, operations, research, etc. If going to train a line manager, need to integrate it as a role and responsibility.

Discussion on authorization – difference between having a piece of paper (which may not know of) and authorizing work. Avoid danger of too much paper.

Issue – HR centers don't understand challenge of keeping up with assignment of supervisors. Who is a supervisor.

You need to know when you're going outside your envelope. Risk-taking behavior in science is predictive.

How do you turn the ship around?

Line Management communications are in one direction – after 5 years, finally asked if there were safety issues needing a fix.

Communication across the laboratory:

- Clean-ups should be done more regularly
- Some of the themes suggest need for training, e.g., roles & responsibility, adequacy of feedback
- Need training in terminology – "risk", etc.

Some places have 60 post-docs (MSD), PBD may have similar challenges –

- Passing supervisory responsibility to post-docs may be dangerous because temporary, no institutional commitment.
- Senior line managers and PIs not in the labs often enough, often off site

How do we improve the situation?

- Need to understand the culture, better articulate
- Movie star studio culture – who enforces safety in a movie studio? Only there to get an Oscar.

EH&S Oversight is ineffective-- from Peer Review

- Don't have a common definition for "safety coordinator"

Issue of Centralization vs. De-Centralization

- Need system of checks and balances
- Are you getting to root causes in the accident investigation process?

Importance of EH&S liaisons getting support of EHS Division Director if they raise safety concerns.

- Is their role oversight? No? What's important is interrelationship between EH&S and line – regulator vs. advisor
- No expectation articulated that liaisons escalate issues, i.e. raise them for resolution.
- Need for mechanism to deal with unreasonable liaison, need to negotiate.

Next Steps:

- See if today's results match up with Peer Review report. We need to feel comfortable with results.
- Will schedule another 2-hour meeting 2 weeks from now to finalize analysis.

Themes

- ALS – Why did we encounter problems in procedural implementation?
- Risk taking is recognized, tolerated and encouraged by workers, supervisors, coworkers, guests and students. Why?
- Insufficient resources for safety
- Procedures are too complex/process is too involved
- Outgrown safety infrastructure

Roles and Responsibilities

- Not all PIs are equal
- Expectations to use the procedures
- Do line managers know how to manage?
- Clear, communicated
- As defined in authorizations (formal and informal)
- Who is a line manager?

Adequacy of Feedback for Improvement Systems – IFA, SA, MESH

- Scope
- CRADs
- Ongoing/periodic/multi-directional views

Inherent conflict between the culture of the research and <u>everything else</u>

- Reward for doing everything else
- Management is not high priority for PIs

Taking Advantage of a Graded Approach

Communication

- Terminology gets in the way (i.e. line management, authorization)
- Making ISM real for workers/researchers

EHS Oversight Ineffective

- Supervision of matrixed people from EHS
- Roles and responsibilities of EHS staff and other divisions (i.e. liaisons, coordinators)
- "User" model vs. traditional model
- EHS vs. line responsibility
- Decentralized too much
- Potential conflict of interest in our systems

CAP Ideas

- DNFSB 2004-1
  - Commitments 23 &25
  - Include assessment of vulnerabilities in CAP
  - Systematic review of effectiveness of EHS programs
  - Streamlined approach to corrections
  - Accommodate "user" model and traditional model of work